

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
REGULATION AND LICENSURE  
CREDENTIALING DIVISION

Check one:  
Initial License  
Change of Location  
Change of Ownership

Home Health Agency Licensure Application

IDENTIFYING INFORMATION

1. FULL NAME OF FACILITY: \_\_\_\_\_ Area Code \_\_\_\_\_ Phone Number \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ Area Code \_\_\_\_\_ Fax Number \_\_\_\_\_  
(Street Address, City, State, Zip)
2. FEDERAL EMPLOYER IDENTIFICATION NUMBER OF THE FACILITY: \_\_\_\_\_  
(If Not Individual)
3. ADMINISTRATOR: \_\_\_\_\_
4. PREFERRED MAILING ADDRESS FOR THE RECEIPT OF OFFICIAL NOTICES FROM THE DEPARTMENT: \_\_\_\_\_
5. SERVICES PROVIDED:
- |                           |                      |                     |
|---------------------------|----------------------|---------------------|
| Nursing                   | Occupational Therapy | Dialysis            |
| Home Health Aide          | Respiratory Therapy  | Speech Therapy      |
| Physical Therapy          | Social Work Practice | Intravenous Therapy |
| Other: Please List: _____ |                      |                     |
6. GEOGRAPHICAL AREA SERVED: (Counties) \_\_\_\_\_
7. BRANCH OFFICE(S) AT LOCATION DIFFERENT FROM PARENT AGENCY (if any – include street address and city): \_\_\_\_\_
8. STARTING DATE OF OPERATION: \_\_\_\_\_
9. ACCREDITING AGENCY: (If applicable) Please check JCAHO CHAP
10. CERTIFICATION: (If applicable) Please check Medicare Medicaid

OWNERSHIP INFORMATION

11. OWNERSHIP OF FACILITY: \_\_\_\_\_  
(Legal Name of Individual or Business Organization)  
ADDRESS: \_\_\_\_\_  
(Street Address, City, State, Zip)
12. MAILING ADDRESS OF OWNERSHIP: \_\_\_\_\_  
(If Different Than Above)
13. BUSINESS ORGANIZATION: (Check one)  
Sole Proprietorship  
Partnership  
Limited Partnership  
Corporation  
Limited Liability Company  
Governmental ( State, District, County, City or Municipal)  
Other (Please Specify) \_\_\_\_\_

CERTIFICATION

I/we have read the Rules and Regulations issued by the Nebraska Department of Health & Human Services and will comply with them should a license be issued. I/we certify that to the best of my/our knowledge, all information and statements on the application and on the attached documents are true and correct and I/we hereby apply for a license. **PLEASE NOTE:** Neb.Rev.Stat. Section 71-433 requires “Applications shall be signed by (1) the owner, if the applicant is an individual or partnership, (2) two of its members, if the applicant is a limited liability company, (3) two of its officers, if the applicant is a corporation, or (4) the head of the governmental unit having jurisdiction over the facility to be licensed, if the applicant is a governmental unit.”

Sign Here \_\_\_\_\_ AUTHORIZED REPRESENTATIVE \_\_\_\_\_ DATE \_\_\_\_\_ AUTHORIZED REPRESENTATIVE \_\_\_\_\_ DATE \_\_\_\_\_

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